



STATE OF IOWA

THOMAS J. VILSACK, GOVERNOR
SALLY J. PEDERSON, LT. GOVERNOR

DEPARTMENT OF HUMAN SERVICES
KEVIN W. CONCANNON, DIRECTOR

October 27, 2006

GENERAL LETTER NO. 3-B-AP-1

ISSUED BY: Office of the Deputy Director for Field Operations

SUBJECT: Employees' Manual, Title 3, Chapter B, Appendix, **STATE RESOURCE CENTERS APPENDIX**, Title page, new; Contents (page 1), new; pages 1 through 11, new; and the following forms:

470-4402	<i>Application for Admission to a State Resource Center</i> , new
470-4403	<i>Resource Center Agreement and Consent for Services</i> , new
470-4367	<i>Resource Center Individual Grievance</i> , new
470-4366	<i>Type 1 Incident Investigation Report</i> , new
470-4345	<i>Type 2 Incident Review Report</i> , new

Summary

This Appendix issues new state-approved forms that are to be used by all state resource centers to document investigation of abuse allegations and individual grievances.

Effective Date

Immediately.

Material Superseded

None.

Additional Information

Destroy all supplies of previous forms created by State Resource Centers that were used to investigate abuse allegations and individual grievances. Forms will only be modified with the permission of the Office of the Deputy Director for Field Operations in Central Office.

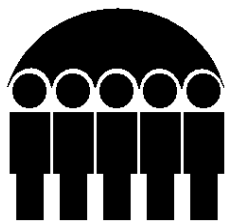
Refer questions about this general letter to your state resource center superintendent.

October 27, 2006

Employees' Manual
Title 3
Chapter B Appendix

STATE RESOURCE CENTERS

APPENDIX



Iowa
Department
of
Human Services

	<u>Page</u>
Application for Admission to a State Resource Center, Form 470-4402	1
Resource Center Agreement and Consent for Services, Form 470-4403	2
Resource Center Individual Grievance, Form 470-4367	3
Type 1 Incident Investigation Report, Form 470-4366	5
Type 2 Incident Review Report, Form 470-4345	9

Application for Admission to a State Resource Center

To: The _____ County Board of Supervisors

I, _____, _____
Name Address

am the _____ of _____
Parent, Guardian, Legal Representative Name of Individual to Be Served

for whom I seek voluntary admission to _____ Resource Center.
I believe the individual is or may be a person with mental retardation. (Attach supporting information.)

Type of admission requested: ☐ Admission ☐ Temporary admission ☐ Outpatient admission

Birth date of individual _____

Signature Date

Signature Date

We, the Board of Supervisors of _____ County, hereby make application
for voluntary admission of _____ to the Superintendent of the
Name of Individual

_____ Resource Center in accordance with Iowa Code sections
222.13 and 222.13A. Our determination is, that the individual for whom application is made

☐ has legal settlement in _____ County or ☐ has no legal settlement.
(If the determination is that legal settlement is in a county other than the county making the application
or the person has no legal settlement, attach documentation to support that determination.)

This application has been made through the central point of coordination process. (CPC signature
required for all applications for an adult individual.)

CPC Administrator Chairperson, County Board of Supervisors

Application approved as a state case: ☐ Yes ☐ No Date _____

Deputy Director, Field Operations

Readmission: ☐ Yes ☐ No

Application for Admission to a State Resource Center, Form 470-4402

Purpose	Form 470-4402 is used to make application for admission to a resource center.
Source	Print the form from the on-line manual or photocopy the sample from the paper manual. Resource centers may print their own supply.
Completion	<p>The first section of the form is completed by the individual who is seeking admission to the resource center, or by the individual's legal representative.</p> <p>The second section of the form is completed by the central point of coordination or the county board of supervisors of either the individual's county of residence or the county of legal settlement.</p> <p>The third section of the form is completed by the deputy director when approval as a state case is requested.</p>
Distribution	The original is submitted to the resource center through the Residential Technical Assistance Team (RTAT).
Data	<p>Information supporting the individual's diagnosis of mental retardation or possible mental retardation is attached.</p> <p>Documentation is attached to support the legal settlement determination if legal settlement is determined to in a county different than the county signing the application or if the determination is that the individual has no legal settlement.</p>

Resource Center Agreement and Consent for Services, Form 470-4403

Purpose	Form 470-4403 is used to obtain consent from an individual or the individual's legal representative for the services to be provided to the individual at the resource center.
Source	The form is as a template available through the resource center superintendent's offices.
Completion	The form is completed as part of the application process for admission to a resource center and is updated at least annually thereafter.
Distribution	The original is retained in the individual's resource center record. One copy is provided to the individual or to the legal representative who signed the form.

Resource Center Agreement and Consent for Services

Agreement

This agreement and consent is between the _____ Resource Center and [name of applicant or legal representative] who mutually agree and consent, each in consideration for the promises of the other, as follows:

Resource Center, as a party to this agreement acknowledges responsibility and agrees with the person signing this consent to:

1. Provide care, treatment, and training for [name of applicant].
2. Provide treatment based on an individual support plan that shall be based on a comprehensive functional assessment. The individual support plan shall include, as needed, a behavior support plan, clinical care plan, risk management plan, and an individual education plan.
3. Develop this plan within 30 days of admission and to update the plan at least annually.
4. Develop the plan and make any revisions with the opportunity for full participation of the applicant and legal representative.
5. Review the plan on a regular basis to identify needed modifications and notify you of any revisions.
6. Notify you of any abuse allegations, serious illness, special treatment, hospitalization, or surgery needed and recommended routinely or in an emergency by a physician or surgeon licensed to practice medicine or surgery.
7. Seek your informed consent for approval for participation in treatment which includes invasive or potentially harmful procedures, programmatic use of restraints, use of a behavior modifying medication, nonemergency transfer to another facility, programmatic use of aversive stimuli or response cost, programmatic use of time out, medical consents that are restrictive based on a medical condition, and participation in experimental research.
8. Protect as confidential all of the individual's care, treatment, and training records and photos. Records and photos are to be used or shared only with your informed consent as indicated in the Resource Center's Notice of Privacy Practices.
9. Provide you with reasonable access to the Resource Center's record for [name of applicant].

Consent

In consideration of the foregoing agreements, I hereby:

1. Consent, except as noted below, to the treatments, evaluations, and services specified in the individual support plan and authorize the Resource Center to provide routine and emergency medical, surgical, dental treatment, and all vaccinations and immunizations prescribed.
 - a. This consent also covers diagnostic procedures, x-ray, laboratory analysis, dental assessment, psychological assessment, psychiatric assessment, speech and language evaluation, audiological evaluation, psychosocial evaluation, chaplaincy assessment, motor functioning assessment, occupational and physical therapy, educational assessment where appropriate, vocational assessment, and other specialized assessments based on the individual's needs.
 - b. Exceptions:
2. I understand that:
 - a. Providing all the information requested is essential to providing the best services and failure to provide information may reduce the quality of a service and limits of liability of the Resource Center to the extent the information is essential to a service. Failure to provide adequate information can lead to discharge.
 - b. No outside person or agency shall have access to my Resource Center record information without my consent.
 - c. My confidential information may be shared with other resource center or the Department of Human Services employees who have a need to know to perform their legal duties.
 - d. The Resource Center shall, upon request, release confidential information to other agencies who have a legal right to the information and who have confidentiality requirements at least as restrictive as those of the Resource Center. These agencies include, but are not limited to, federal and state auditors, Social Security Administration, Internal Revenue Service, Department of Education, Area Education Agency, Iowa Foundation for Medical Care, Department of Inspections and Appeals, and Iowa Protection and Advocacy.
 - e. The Resource Center's focus for the individuals it serves is to work on barriers to discharge that exist for the individual with the goal of helping the individual move to the most integrated setting consistent with the individual's needs and choice.
 - f. Placement planning may require that I provide additional information to complete applications for various community facilities and, if necessary, I will be asked to consent to the release of confidential information at that time.

I hereby certify that I have read, or have had read to me, and fully understand the contents of the above agreements and the reasons why consent to same has been requested and is granted.

This consent is valid until .

I understand that I have the right to change or withdraw this consent at any time.

Applicant (or Legally Authorized Representative)

Date

Resource Center Representative

Date

Title

Resource Center Individual Grievance

Statement of Grievance

State your concern. Explain the facts as best you understand them. Your parent, guardian, legal representative, family or an employee is a resource for you in advocating for your rights. You may ask any of these persons to help you. We encourage you to contact them to help you with expressing your concern.

Signature

Date

Person Assisting (Print Name)

Findings/Resolution By

Provide summary of discussion, solutions offered, reasons individual did or did not agree to resolution.

Resident Treatment Supervisor (RTS)/First Line Supervisor

Date received for review _____

Date of response _____

Resolved: ☐ Yes ☐ No

Signature _____

Date _____

Treatment Program Manager (TPM)

Date received for review _____

Date of response _____

Resolved: ☐ Yes ☐ No

Signature _____

Date _____

Treatment Program Administrator (TPA)

Date received for review _____

Date of response _____

Resolved: ☐ Yes ☐ No

Signature _____

Date _____

Grievance has been sent to HRC as of this date _____

Human Rights Committee Worksheet

Date received copy of grievance _____

Date received from Treatment Program _____

Administrator for investigation _____

Grievance Subcommittee Members Assigned

Work of the Grievance Subcommittee

Documentation of Investigation and Facts Relied On

Findings and Conclusion of Investigation
(To be completed in 10 business days of receipt from TPA.)

Recommended Action and Resolution of the Grievance
(To be completed within 5 business days of completion of investigation.)

Date of Human Rights Committee decision _____

Resource Center Individual Grievance, Form 470-4367

Purpose	Form 470-4367 is to be used for the filing of formal grievances and recording the process and findings of the investigation.
Source	Print the form from the on-line manual or photocopy the sample from the paper manual. Resource centers may print their own supply.
Completion	<p>The individual filing the grievance completes the first section providing a statement as to the actions the individual is grieving.</p> <p>The remainder of the form is completed by the employees who try to resolve the grievance and, if the grievance is not resolved, by the Human Rights Committee.</p> <p>Within five business days, the resident treatment supervisor and treatment program manager shall investigate the grievance and try to resolve it at their level. (For example, if the resident treatment supervisor takes three days, then the treatment program manager has only two days.)</p> <p>If resolution is not possible, the grievance is sent on to the treatment program administrator. Within five business days, the treatment program administrator investigates the grievance and tries to resolve it.</p> <p>If resolution is not possible, the grievance is sent to the Human Rights Committee for investigation, findings, and a recommendation.</p>
Distribution	<p>After completion by the individual filing the grievance, give the original to the individual's resident treatment supervisor and send a copy to the chairperson of Human Rights Committee. Attach to the form any collateral information collected as part of the investigation.</p> <p>When the investigation and findings are completed, provide copies to:</p> <ul style="list-style-type: none">◆ The individual filing the grievance◆ The treatment program administrator◆ The superintendent.◆ The Quality Management Office

Data

The individual filing a grievance, or a person assisting the individual, provides the statement describing the grievance and desired resolution and signs and dates the statement.

Staff for the Human Rights Committee complete the following items:

- ◆ Date received copy of grievance: Enter the date the grievance is referred to the Human Rights Committee for investigation.
- ◆ Date received from Treatment Program Administrator for investigation: Self-explanatory.
- ◆ Grievance subcommittee members assigned: List the names of the assigned subcommittee.
- ◆ Work of the grievance subcommittee: Provide a summary of the work and process the subcommittee used to investigate the grievance, including:
 - Who was interviewed,
 - What documents were used,
 - What written statements were received for the investigation.
- ◆ Documentation of investigation and facts relied on: Self-explanatory.
- ◆ Findings and conclusions of the investigation: Summarize the committee's findings of fact and conclusions as a result of the investigation.
- ◆ Recommended action and resolution of the grievance: Describe the recommendations the committee has for resolution of the grievance, including recommended corrective actions.
- ◆ Date of Human Rights Commission decision: Enter the date of the Committee's decision.

Type 1 Incident Investigation Report

This form is to be used by the resource center investigator to prepare the written report of the investigation into all type 1 incidents and by the Incident Review Committee to determine appropriate actions needed as a result of the investigation. See 3-B-Appendix for instructions.

I. Basic Information	
Investigation Report	
Investigation number	ID number
Name of alleged victim <input type="checkbox"/> Adult <input type="checkbox"/> Child	House address
Date incident allegedly occurred	Time alleged incident to have occurred
Location of incident	
Date/time reported to DIA	Reported to
Date/time investigation assigned	Date investigation completed
Name and title of primary investigator assigned	
Description of the incident	
Names of alleged perpetrators	
Names of persons reporting the incident	
Immediate protections implemented	
Immediate actions taken with alleged perpetrators	
Names of all witnesses (employees, volunteers, contractors, individuals, others)	

Type of incident (check all that apply):

- | | |
|---|--|
| <input type="checkbox"/> Alleged abuse | <input type="checkbox"/> Suspicious injury |
| <input type="checkbox"/> Physical | <input type="checkbox"/> Injury resulting from restraint |
| <input type="checkbox"/> Sexual | <input type="checkbox"/> Suicide attempt |
| <input type="checkbox"/> Verbal | <input type="checkbox"/> Individual physical or sexual assault of another individual |
| <input type="checkbox"/> Mental or psychological | |
| <input type="checkbox"/> Neglect or denial of critical care | <input type="checkbox"/> Other incidents in which an initial Type 2 incident review or clinical or interdisciplinary team review indicates a potential allegation of abuse |
| <input type="checkbox"/> Exploitation | <input type="checkbox"/> Other incident assigned for investigation by the Superintendent or Deputy Director |
| <input type="checkbox"/> Serious injury | |
| <input type="checkbox"/> Death | |
| <input type="checkbox"/> Suspicious | |
| <input type="checkbox"/> Unexpected deaths | |

II. Investigative Procedure

A. General Information

1. List the dates and times the investigator visited the site of the incident.
2. List the persons with whom the investigator spoke at that site. (Not witness interviews.)

B. Collecting Physical and Demonstrative Evidence

1. Describe the manner in which the scene of the incident, if any, was secured.
2. List each piece of physical evidence collected.
3. Describe the manner in which the physical evidence was collected and logged.
4. Describe the manner in which the physical evidence was kept after collection in order to maintain the chain of custody.
5. List any pictures that were taken.
6. List any demonstrative evidence available to the investigation (e.g., diagrams, maps, floor plans, x-rays).

C. Testimonial Evidence

1. Describe the way in which the investigator determined whom to interview.
2. List all persons interviewed in chronological order, including name, title, date and time, and type of interview (e.g., face-to-face, telephone).
3. Report the questions asked and answers given of all individuals identified in II.C.2.
4. List the person or persons, if any, identified as the target or targets of the case.
5. Describe the way in which the investigator afforded the target or other witnesses any right to representation if such rights exist by contract or other regulation or by law.
6. For any person identified in II.C.4., note whether the person had been suspended pending the investigation, whether any such person was reinstated during the course of the investigation and the reason for the reinstatement. If no one was suspended, please explain.
7. List any previous investigations that were reviewed as relevant to determine the circumstances, the veracity of witnesses, or corrective actions to be proposed.

D. Documentary Evidence

1. List any statements taken from individuals interviewed in the case. (This may be noted, for convenience, on the list identified in II.C.2., above.)
2. List any other documents collected in this case.
3. Describe the manner in which any business records that were collected were secured prior to and after their collection.

III. Summary of Evidence

- A. List the investigatory questions that the investigator must answer.
- B. Provide a summary of all direct evidence available to answer each question. (Information to be a fair summary related to each question.)

- C. Provide a summary of all circumstantial evidence available to answer each question. (Information to be a fair summary related to each question.)

IV. Analysis and Findings

Include an answer to each investigatory question identified in III. Summary of Evidence and the reasons for your conclusion.

V. Disposition of Case #

(To be completed by the Incident Review Committee in consultation with the investigator.)

Part I. For allegations or suspicions of abuse and neglect including allegations and suspicions arising during the investigation, based on the findings noted in section IV, we believe that the allegation has been:

☐ Substantiated

☐ Unsubstantiated

☐ Inconclusive

Part II. For all other matters (e.g., serious injuries of unknown origin), based on the findings noted in section IV, we believe the investigatory question has been:

☐ Resolved

☐ Not resolved

VI. Recommendations (To be completed by the Incident Review Committee.)

Based on the findings of the investigation and the discussions within the Incident Review Committee, we make the following recommendations that we believe are necessary to better protect people from harm.

VII. Corrective Action Plan

(To be completed by the Incident Review Committee in consultation with the investigator.)

Are corrective actions needed? ☐ Yes ☐ No

If Yes, person responsible for development of corrective action plan:

VIII. Incident Investigation Quality Assurance Follow-up (Administrative review)
(To be completed by the director of Quality Management.)

Case number:

Were problems timely and adequately detected? ☐ Yes ☐ No

If the answer is No, explain:

Were protections timely and adequately implemented? ☐ Yes ☐ No

If the answer is No, explain:

IX. Corrective Action Plan Review (Administrative review)
(To be completed by the Incident Review Committee.)

Plan developed within five business days of assignment? ☐ Yes ☐ No

Plan contained necessary components:

Tasks ☐ Yes ☐ No

Timeline ☐ Yes ☐ No

Outcomes ☐ Yes ☐ No

Employee responsible for implementation ☐ Yes ☐ No

Corrective action plan implemented in timely manner? ☐ Yes ☐ No

Results of corrective action plan documented? ☐ Yes ☐ No

Recommendations for further corrective action plan steps. (The Incident Review Committee shall address any "No" responses related to the development, implementation, and documentation of corrective action plan.)

Type 1 Incident Investigation Report, Form 470-4366

Purpose	Form 470-4366 provides the outline and format for investigation of Type 1 incidents. The investigator provides the completed form to the Director of Quality Management. This form is divided into two components. Sections I through VII are the official report of the investigation including the findings and recommendations. Sections VIII and IX are not part of the official report. These two sections are for internal administrative review of the overall implementation of the investigation process.
Source	This form is a template available through the resource center superintendent's office.
Completion	The investigator shall complete sections I through IV for each investigation. Sections V through VII are completed by the Incident Review Committee in consultation with the assigned investigator. Section VIII is completed by the Director of Quality Management. Section IX is completed by the Incident Review Committee.
Distribution	After the review is completed, forward the original to the superintendent. Quality Management retains one copy. Attach any collateral information to the report.
Data	<p>Section I. Basic Information:</p> <p>Investigation number. Sequential number assigned by resource center.</p> <p>ID number. Individual's resource center case number.</p> <p>Name of alleged victim. Individual involved in the incident or individual. Only one individual can be named on a form. If more than one individual involved, list each individual on a separate form. (Indicate adult or child.)</p> <p>House address. Number/name of unit individual lives in.</p> <p>Date incident allegedly occurred. Date incident occurred.</p>

Time alleged incident to have occurred. Time incident is alleged to have occurred.

Location of incident. Where alleged incident occurred. (House, program area, treatment area, on campus, off campus, etc.)

Date/time reported to DIA. Date and time alleged abuse incident was reported to the Department of Inspection and Appeals.

Reported to. Name of employee to whom report was made.

Date/time investigation assigned. Date and time the investigation was assigned to an investigator.

Date investigation completed. Date the investigation was completed and sent to next step.

Name and title of primary investigator assigned. The name and title of the primary investigator.

Description of the incident. A complete statement as to what occurred is alleged to have occurred.

Names of alleged perpetrators. Completed only for incidents involving allegations of abuse. If more than one person is alleged, list all persons alleged by individual name.

Names of persons reporting the incident. If more than one person reported the incident, list all persons who made a report by individual name.

Immediate protections implemented. If protection was required, describe what actions were taken to protect health and safety of the individual.

Immediate actions taken with alleged perpetrators. Completed only for incidents involving allegations of abuse. Was alleged perpetrator removed from direct contact with individual, reassigned, or was employee placed on leave with pay?

Names of all witnesses (employees, volunteers, contractors, individuals, others). List the names of all persons who were present when the incident occurred and who witnessed the incident first hand.

Type of incident. Check type of incident being investigated. Check all that apply.

Section II. Investigative Procedure

This section is completed by the investigator by addressing all questions asked.

Section III. Summary of Evidence

Investigator provides a summary of questions asked, evidence available, and circumstantial evidence.

Section IV. Analysis and Findings

Investigator provides conclusions based on available evidence and reasons for the conclusions made.

Section V. Disposition of Case

Complete by the Incident Review Committee. In allegations of abuse, determines whether substantiated, unsubstantiated, or inconclusive. For all other incidents, determined whether or not resolved.

Section VI. Recommendations

Completed by Incident Review Committee. Provides any recommendations determined appropriate to provide individuals with improved protections from harm.

Section VII. Corrective Action Plan

Identifies whether or not corrective actions are needed and if needed, person responsible for development of the plan.

Section VIII. Incident Investigation Quality Assurance Follow-up

Completed by Director of Quality Assurance. Provides assessment of whether problems were timely and adequately detected and whether protections were timely and adequately implemented.

Section IX. Corrective Action Plan Review

Completed by the Incident Review Committee. Provides a summary of development and implementation of corrective actions. Recommendations of further corrective actions are provided as needed.

Type 2 Incident Review Report

This form is to be used by the resource center employee assigned to review an incident and prepare the written report for all type 2 incident reviews. See 3-B-Appendix for instructions.

I. Basic Information	
Review Report	
Review number	ID number
Name of individual <input type="checkbox"/> Adult <input type="checkbox"/> Child	House address
Date incident allegedly occurred	Time alleged incident to have occurred
Location of incident	
Date/time incident reported to supervisor	Supervisor reported to
Date/time review assigned	Date review completed
Name and title of employee assigned to review	
Description of the incident	
Names of employees involved	
Names of persons reporting the incident	
Immediate protections implemented	
Immediate actions taken with employees	
Names of all witnesses (employees, volunteers, contractors, individuals, others)	

Type of incident (check all that apply):

- | | |
|--|--|
| <input type="checkbox"/> Accident on or off campus resulting in injury | <input type="checkbox"/> New onset seizure |
| <input type="checkbox"/> Adverse drug reaction | <input type="checkbox"/> Pica |
| <input type="checkbox"/> Aspiration pneumonia | <input type="checkbox"/> Self injury |
| <input type="checkbox"/> Assault by an individual to an employee | <input type="checkbox"/> Significant weight change |
| <input type="checkbox"/> Assault by an individual to a peer | <input type="checkbox"/> Site infection |
| <input type="checkbox"/> Bowel obstruction | <input type="checkbox"/> Skin breakdown |
| <input type="checkbox"/> Choking | <input type="checkbox"/> Status epilepticus |
| <input type="checkbox"/> Elopement | <input type="checkbox"/> Suicide gesture |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Suspension or termination at work, school, etc. |
| <input type="checkbox"/> Injury of unknown origin | <input type="checkbox"/> Other (specify): |
| <input type="checkbox"/> Medical emergency | |
| <input type="checkbox"/> Medication error | |

II. Review Procedure

A. General Information

1. List the dates and times the reviewer visited the site of the incident.
2. List the persons with whom the reviewer spoke at that site of the incident.

B. Information Related to the Incident

1. Describe the incident, impact on the individual, and employee actions or inactions related to incident.
2. Summarize the findings of the record review including, but not limited to, event logs, flow sheets, and case record.
3. Summarize the findings of any environmental review including, but not limited to, bedrails, wheelchairs, floors, etc.

C. Interview Findings

1. List all the employees and individuals the reviewer interviewed to collect information regarding the incident.
2. Information describing the incident as provided by the employees interviewed. Report based on each employee interviewed.

3. Information describing the incident as provided by the individual involved or other individuals. Report based on each individual interviewed.

III. Analysis and Recommendations

- A. Was the incident as reported? If type modified, explain.
- B. What impact did the incident have on the health and safety of the individual? Explain.
- C. Was a cause of the incident identified? Explain.
- D. Did employees respond appropriately to protect the health and safety of the individual? Explain.
- E. Was the incident reported in a timely manner? If not, explain.
- F. Is a corrective action plan required? If no, explain. If yes, describe including:
1. The corrective action required.
 2. Which employee is responsible for developing the corrective action plan.
 3. Which employee is responsible for implementing the corrective action plan.
 4. Dates by which corrective action is to be developed and implemented.
- G. Is this incident a part of a pattern of incidents involving this individual or the employees?
- H. Other recommendations? Specify.

Incident Reviewer

Date

Title

IV. Treatment Program Manager Review

- A. Was the review of the incident appropriate and complete?
- B. Was appropriate action taken to protect the health and safety of the individual?
- C. Was the incident reported and the review done in a timely manner? If no, explain.
- D. Was the determination of need or no need for corrective action appropriate?
- E. Was a clinical or interdisciplinary team review required? If yes, was it completed?
- F. Is this incident a part of a pattern of incidents involving this individual or the employees?
- G. Recommendations for further actions needed.

Treatment Program Manager

Date

Type 2 Incident Review Report, Form 470-4345

Purpose	Form 470-4345 provides an outline and format for reviews done of Type 2 incidents. The reviewer provides the completed form to the treatment program manager.
Source	This form is a template available through the resource center superintendent's office.
Completion	The reviewer shall complete sections I through III. Section IV is completed by the treatment program manager.
Distribution	After the review is completed, forward the original to the treatment program manager. Attach any collateral information to the report.
Data	<p>Section I. Basic Information:</p> <p>Review number. Sequential number assigned by resource center. (If used)</p> <p>ID number. Individual's resource center number.</p> <p>Name of individual. The name of the individual involved in the incident. Only one individual can be named on a form. If more than one individual involved, list individual on a separate form. (Indicate adult or child.)</p> <p>House address. Number/name of unit individual lives in.</p> <p>Date incident allegedly occurred. Date incident occurred.</p> <p>Time alleged incident to have occurred. Time incident occurred.</p> <p>Location of incident. Where alleged incident occurred. (House, program area, treatment area, on campus, off campus, etc.)</p> <p>Date/time incident reported to supervisor. Date and time the incident was reported by an employee, volunteer, or contractor to a supervisor.</p>

Supervisor reported to. Name of supervisor to whom report was made.

Date/time review assigned. Date and time the review was assigned to the reviewer.

Date review completed. Date the review was completed and sent to the treatment program manager.

Name and title of employee assigned to review.

Description of the incident. A complete statement as to what occurred or is alleged to have occurred.

Names of employees involved. If the incident is the result of an inaction or action on the part of an employee, enter the name.

Names of persons reporting the incident. If more than one person reported the incident, list all persons who made the report by individual name.

Immediate protections implemented. If protection was required, describe what actions were taken to protect the health and safety of the individual.

Immediate actions taken with employees. Completed only for incidents involving allegations of employee, volunteer, or contractor wrong doing.

Names of all witnesses (employees, volunteers, contractors, individuals, others). List the names of all persons who were present when the incident occurred and who witnessed the incident first hand.

Type of incident. Check type of incident being reviewed. Check all that apply. If type of incident is not on the list, check other and specify the type of incident.

Section II. Review Procedure

This section is completed by the reviewer by providing the information requested.

Section III. Analysis and Recommendations

This section is completed by the reviewer by answering the questions asked and as appropriate, providing requested information. Reviewer signs and dates the completed review.

Section IV. Treatment Program Manager Review

This section is completed by the program treatment manager by answering the questions and, as appropriate, providing further recommendations for other actions. Treatment program manager signs and dates.